



❖ MISSOURI DEPARTMENT OF MENTAL HEALTH ❖ APPLICATION FOR SHELTER PLUS CARE INFORMATION

WHAT IS SHELTER PLUS CARE (SPC)? SPC is long-term rental assistance for eligible applicants. The program pays all or part of the program participant's rent, depending on household income; a one-time security deposit; and in some cases a utilities allowance. Program participants must be in case management and be receiving services for a mental health disability to continue to qualify. Assisted rental units are inspected annually to ensure housing quality standards are met, and participants must annually recertify their household income, household composition and case management status.

APPLICANT ELIGIBILITY. Applicants for Shelter Plus Care must be 1) disabled (see Attachment A for the list of eligible disabilities); 2) receiving mental health services through case management and have a Treatment Plan (see Attachment B); 3) homeless at the time they are approved for assistance (see Attachment C for a list of what settings qualify as homelessness); and 4) have a combined household income of no more than 50% of their Area Median Income (a.k.a. "very low income").

AGENCY STANDING TO SUBMIT AN APPLICATION. With the assistance of the consumer, an application for SPC must be filled out and submitted by a Case Manager who is employed by a service provider contracted with the Departments of Mental Health or Health and Senior Services to provide mental health or HIV/AIDS services. DMH Housing also accepts applications from non-contracted agencies that have been **pre-approved** to submit applications. **Applications cannot be accepted directly from consumers.** If the agency is not able or willing to ensure that the applicant has access to long-term case management, the application should not be submitted. **Long-term case management is essential for the success of SPC program participants.**

TIPS FOR FILLING OUT THE APPLICATION:

- Be sure to fill out the **Treatment Plan** (Attachment B) form completely, especially the section dealing with housing. Housing self-sufficiency is a major goal of Shelter Plus Care; your agency must include housing in a consumer's Treatment Plan in order to submit an application for that consumer.
- Discuss with the applicant their complete recent housing history before you fill the application out. If your client has never been homeless **within HUD's definition (see Attachment C)**, they will not qualify for this assistance.
- Fill out **everything**; if an item does not apply to your client, indicate "N/A".
- Be sure that every item that requires a signature has one.
- Make sure the Applicant has not signed by mistake in a place where either you or a third party is required to sign.

IMPORTANT: To complete this application you **must** attach the following documentation:

- **Documentation of homelessness.** See Attachment C, Verification of Homeless, for a description of what documentation is required. Failure to include this documentation will prevent processing of this application.
- **Legal status.** If the applicant is a legal non-citizen, documentation of legal status must be included.
- **False statements made on this application may result in denial or termination of assistance.**

GENERAL INFORMATION:

- For assistance with this application, contact the DMH Housing Unit at housing@dmh.mo.gov or at **573-526-3125**.
- For application processing and wait list information, call the following:
 - For **St. Louis City and County**: 573-751-8208; for **Kansas City, Independence, Joplin and St. Joseph**: 573-526-3125; for **all other areas**: 573-522-6519
- **FAX completed application to the DMH Housing Unit at 573-526-7797.**
- This form may be downloaded as a PDF file at www.dmh.mo.gov/ada/housing/ShelterPlusCare.htm#ApplyingforSPCAssistance. A filled out sample Application is also available at the same link.



❖ MISSOURI DEPARTMENT OF MENTAL HEALTH ❖ APPLICATION FOR SHELTER PLUS CARE CHECKLIST

The purpose of this checklist is to assist you in completing an Application for Shelter Plus Care—you do not have to submit this page with the application.

- ☐ Sections 1-8 of the Application are filled out completely.
- ☐ The Applicant (and co-Applicant, if any) has signed the Applicant Certification (following Section 8).
- ☐ **Attachment A** (Disability Verification) is completely filled out with ONE option checked and is signed by a person with the proper credentials.
- ☐ **Attachment B** (Treatment Plan) is completely filled out. Please **do not** attach a copy of the original Treatment Plan.
- ☐ **Attachment C** (Homelessness Verification) is completely filled out with ONE option checked and is signed by the Case Manager.
- ☐ Complete documentation of the applicant's homelessness is attached (*see Attachment C* for required documentation).
- ☐ **Attachment D** (Chronic Homelessness Verification) is completely filled out to indicate whether or not the applicant fits the definition of "chronically homeless".
- ☐ Documentation of the Applicant's chronic homelessness is attached, if needed (*see Attachment D* for the definition of chronic homelessness).
- ☐ **Attachment E** (Required HMIS Information) is completely filled out.
- ☐ **Attachment F** (Authorization for Disclosure of Consumer Medical /Health Information) is completely filled out and signed by the Applicant and a witness.
- ☐ A copy of the Applicant's documentation of **legal non-citizen** status is attached, if applicable.



APPLICATION FOR SHELTER PLUS CARE

➤SECTION 1. APPLICANT INFORMATION

Last Name: _____ First Name: _____ Middle Initial: _____

Current Address: _____ Apt. #: _____

City: _____ State: _____ Zip: _____

Phone: (_____) _____ Other Contact Info?: _____

➤SECTION 2. CASE MANAGER INFORMATION

Case Manager Name: _____

Agency: _____

Address: _____

Office Phone: (_____) _____ Fax: (_____) _____

Alt. Phone: (_____) _____ Email: _____

➤SECTION 3. EMERGENCY CONTACT INFORMATION

Name: _____ Relationship: _____

Address: _____ Apt. #: _____

City: _____ State: _____ Zip: _____

Phone: (_____) _____ Other Contact Info?: _____

For DMH Use Only

Metro KC <input type="checkbox"/>	Independence <input type="checkbox"/>	KC Chronic <input type="checkbox"/>	Joplin-St. Joseph <input type="checkbox"/>
St. Louis City <input type="checkbox"/>	St. Louis County <input type="checkbox"/>	St. Louis Chronic <input type="checkbox"/>	Bootheel <input type="checkbox"/>
Branson <input type="checkbox"/>	Farmington <input type="checkbox"/>	Hannibal <input type="checkbox"/>	Kirksville <input type="checkbox"/>
Poplar Bluff <input type="checkbox"/>	Rolla <input type="checkbox"/>	Springfield <input type="checkbox"/>	West Plains <input type="checkbox"/>
Forms: Disability <input type="checkbox"/> Homeless <input type="checkbox"/> Chronic <input type="checkbox"/> HMIS <input type="checkbox"/> HIPAA <input type="checkbox"/> Treatment Plan <input type="checkbox"/>			
Eligibility: Disabled <input type="checkbox"/> Homeless <input type="checkbox"/> Income <input type="checkbox"/>			
Disability: SMI <input type="checkbox"/> CSA <input type="checkbox"/> SMI/CSA <input type="checkbox"/> PWA <input type="checkbox"/> PWOD <input type="checkbox"/>			
Chronic: Yes <input type="checkbox"/> No <input type="checkbox"/>			
Referral:		MO	
Processing Center		Grant Code	
		HUD Grant Number	
		Date Referred	

Applicant's Name: _____

➤SECTION 4. APPLICANT'S HOUSEHOLD COMPOSITION

In the space below, please give the requested information about the Applicant and any other people who will live with the Applicant in the assisted household (spouse, children, significant other, etc.).

Include any children not currently in the Applicant's custody but for whom the Applicant expects to receive custody after obtaining permanent housing. Please do not list anyone currently living with the Applicant who will not live in the Shelter Plus Care assisted household.

Household Member's Full Name	Race Code(s)	Hispanic? Yes or No	Relationship to Applicant (spouse, mother, son, etc.)	Marital Status (single, married, divorced, separated)	Gender 'M' or 'F'	Disability Code(s)	Date of Birth	Social Security Number
(Applicant's Name)			Self					

RACE CODES		DISABILITY CODES	
A.	American Indian/Alaska Native	A.	Serious mental illness
B.	Asian	B.	Alcohol abuse
C.	Black/African-American	C.	Drug abuse
D.	Native Hawaiian/Other Pacific Islander	D.	Developmental disability/mental retardation
E.	White	E.	Dual diagnosis (mental illness with substance abuse)
F.	Multi-Racial (if multi-racial, please also enter codes A-E to specify)	F.	HIV/AIDS and related disease

Citizenship: U.S. Citizen ☐ Non-Citizen ☐ -----➤

What is the Applicant's primary language? _____

If English is not the Applicant's primary language, can the Applicant speak limited English? Yes ☐ No ☐

Does the Applicant have picture ID? Yes ☐ No ☐

NOTE: Non-citizens *must* provide federally-issued documentation of their legal status as an immigrant.

Applicant's Name: _____

➤SECTION 5. INCOME INFORMATION

Please answer each of the following questions. For each "Yes" answer, give details in the Comments section that follows.

1. Is any member of your household employed, full-time, part time or seasonally?Yes ☐ No ☐
2. Does any member of your household expect to work for any period during the next 12 months?Yes ☐ No ☐
3. Does any member of your household work for someone who pays them cash?Yes ☐ No ☐
4. Is any member of your household on leave of absence from work due to layoff, medical, maternity, military leave?
.....Yes ☐ No ☐
5. Does any member of your household now receive, or expect to receive unemployment?Yes ☐ No ☐
6. Does any member of your household now receive or expect to receive child support?Yes ☐ No ☐
7. Is any member of your household entitled to child support that he/she is not now receiving?Yes ☐ No ☐
8. Does any member of your household now receive or expect to receive alimony?Yes ☐ No ☐
9. Is any member of your household entitled to alimony that he/she is not now receiving?Yes ☐ No ☐
10. Does any member of your household receive or expect to receive welfare, such as TANF?Yes ☐ No ☐
11. Does any member of your household receive or expect to receive Social Security?Yes ☐ No ☐
12. Does any member of your household receive or expect to receive income from a pension or annuity?Yes ☐ No ☐
13. Does any member of your household receive cash contributions from individuals/agencies not living in the unit?
.....Yes ☐ No ☐

COMMENTS: _____

For each type of income that the Applicant or anyone who lives with the Applicant receives, please give the source of the income and the amount of the income that can be expected from the source during the next 12 months.

Household Member's Name	Source or Type of Cash Income (employment, SSDI, TANF, etc.)	Monthly Amount	Non-Cash Benefits (such as food stamps)	Monthly Amount

COMMENTS: _____

Applicant's Name: _____

➤SECTION 6. ASSETS INFORMATION

Please list all checking, savings, and investment accounts below for all persons that will be living in your household.

Household Member's Name	Bank Name	Account Number	Type of Account (checking, savings, investment)	Current Balance

List the value of all stocks, bonds, trusts, pension contributions or other assets: _____

Have you sold or given away any real property or assets in the past two (2) years? Yes ☐ No ☐

If yes, what is the current market value of the asset: _____

➤SECTION 7. ZERO INCOME

- If the Applicant has income, please check this box ☐ and skip Section 7.
- If the Applicant has no income, please fill out Section 7, below.

APPLICANT: If you have no income, please read the statement below, then print your name, sign your name, and fill in the date. *Please be aware that falsification of this statement is grounds for denial or termination of housing assistance.*

To the best of my knowledge and belief, I have no income at the time of making this application.

➤ _____ (Print Applicant Name) ➤ _____ (Sign Applicant Name) ➤ _____ (Date)

CASE MANAGER: If the Applicant has no income, please read the statement below, then print your name, sign your name, and fill in the date.

To the best of my knowledge and belief, _____ (print applicant name) has no income at the time of making this application.

➤ _____ (Print Case Manager Name) ➤ _____ (Sign Case Manager Name) ➤ _____ (Date)

➤SECTION 8. EXPENSES

Do you pay childcare, which enables you or another household member to work or go to school? Yes ☐ No ☐

If "Yes", give name and address of the childcare provider, weekly cost and name of household member working/in school:

Provider Name & Address: _____

Name of household member: _____ Weekly Cost: _____

Do you pay for a care attendant or for any equipment for the disabled member(s) of the household necessary to permit that person or someone else in the household to work? Yes ☐ No ☐

List household members who receive Medicaid or Medicare: _____

Do you owe money on back rent? Yes ☐ No ☐ If "Yes", amount: \$ _____

Do you owe money on past utility bills? Yes ☐ No ☐ If "Yes", amount: \$ _____

➤APPLICANT CERTIFICATION

Signature of Applicant: ➤ _____

Date: ➤ _____

Signature of Co-Applicant: ➤ _____

Date: ➤ _____

➤ ADDITIONAL INFORMATION RELATED TO ESTABLISHING THE APPLICANT'S HOMELESSNESS

Please use this space if needed to supply more information that DMH may need to determine the applicant's eligibility.

This image shows a single sheet of white paper with horizontal ruling lines. The lines are evenly spaced and run across the width of the page. There are no margins, text, or other markings on the paper.

Applicant's Name: _____

➤ ATTACHMENT A. VERIFICATION OF DISABILITY

PURPOSE: This form is used to identify the Applicant's *primary* disability that impedes the Applicant's ability to work and live independently. If the Applicant has multiple disabilities, please choose only the one that most substantially impedes the Applicant's ability to work and live independently.

This form may be signed only by a person with one of the following licenses or credentials and who 1) is authorized by their agency to make this type of determination, and 2) maintains appropriate documentation related to the assessment or diagnosis:

Medical Doctor (MD)	Licensed Professional Counselor (LPC)
Psychiatrist	Licensed Clinical Social Worker (LCSW)
Psychologist	Certified Substance Abuse Counselor* (CSAC)
Nurse Practitioner (NP)	*CSAC may ONLY indicate an alcohol or drug abuse diagnosis

I have determined that this individual is disabled as follows:

- ☐ The applicant has a **serious mental illness** that is expected to be of long-continued and indefinite duration; substantially impedes this person's ability to live independently; and is of such a nature that it could be improved by more suitable housing conditions.
- ☐ The applicant has a **chronic alcohol abuse disorder** and/or a **chronic drug abuse disorder** that is expected to be of long-continued and indefinite duration; substantially impedes this person's ability to live independently; and is of such a nature that it could be improved by more suitable housing conditions.
- ☐ The applicant is **dually diagnosed** with **both** a chronic alcohol or drug abuse disorder **and** a serious mental illness that are expected to be of long-continued and indefinite duration; substantially impede this person's ability to live independently; and are of such nature that they could be improved by more suitable housing conditions.
- ☐ The applicant has a **severe and chronic developmental disability** that:
1. Is attributable to a mental or physical impairment or combination of mental and physical impairments;
 2. Manifested before the person attained the age of 22;
 3. Is likely to continue indefinitely;
 4. Results in substantial functional limitations in three or more of the following areas of major life activity (*please check three or more of the following*):
 - ☐ Self-care
 - ☐ Receptive and expressive language
 - ☐ Learning
 - ☐ Mobility
 - ☐ Self-direction
 - ☐ Capacity for independent living
 - ☐ Economic self-sufficiency; and
 5. Reflects the person's need for a combination and sequence of special, interdisciplinary, or generic care, treatment, or other services that are of lifelong or extended duration and are individually planned and coordinated.
- ☐ The applicant **has** a **physical or mental disability caused by HIV/AIDS or related disease** that is expected to be of long-continued and indefinite duration; substantially impedes this person's ability to live independently; and is of such a nature that it could be improved by more suitable housing conditions.

➤ _____
(Print Name of Person Verifying Disability)

➤ _____
(Signature of Person Verifying Disability)

➤ _____
(Profession, e.g., "Psychiatrist", "LCSW", etc.)

➤ _____
(Date)

Required: List license or certification number: ➤ _____

Applicant's Name: _____

➤ **ATTACHMENT B. TREATMENT PLAN**

PURPOSE: This form is used to identify the basic components of the Applicant's treatment plan. All Applicants for Shelter Plus Care must have long-term case management that includes a treatment plan, and the treatment plan must include goals for increasing self-sufficiency and income. Check the boxes next to the services to be utilized and state the frequency of current service usage and/or the date that the service is planned to begin in the future.

☐ **Mental Health Services**

- ☐ Doctor, Psychologist or Psychiatrist visits: _____
- ☐ Therapist visits: _____
- ☐ Group therapy: _____
- ☐ Case management: _____

☐ **Substance Abuse Treatment and Aftercare**

- ☐ Treatment services: _____
- ☐ Aftercare: _____
- ☐ Case management: _____
- ☐ AA/NA meetings: _____
- ☐ Relapse plan and sponsor: _____

☐ **Developmental Disability Services**

- ☐ Doctor visits: _____
- ☐ Therapist visits: _____
- ☐ Case management: _____

☐ **Employment and Training**

- ☐ Vocational rehabilitation: _____
- ☐ Supported employment: _____
- ☐ Case management follow-ups: _____
- ☐ Employment and training goals: _____

☐ **Income and Benefits**

- ☐ Applied for benefits: _____
- ☐ Appeals for benefits: _____
- ☐ Benefits goals: _____
- ☐ Case management follow-ups: _____

☐ **Housing Goals**

- ☐ Housing priorities: _____
- ☐ Securing rental unit: _____
- ☐ Furniture & household items: _____
- ☐ Schedule of case management home visits: _____

Additional Comments: _____

➤ _____
(Signature of Applicant)

➤ _____
(Date)

➤ _____
(Signature of Case Manager)

➤ _____
(Date)

Applicant's Name: _____

➤ ATTACHMENT C. VERIFICATION OF HOMELESSNESS

PURPOSE: This form should be used to describe the Applicant's homelessness situation on or about the day that this application is signed by the Applicant. If none of the choices below apply to the Applicant, then that person is not currently eligible for Shelter Plus Care assistance.

Please be sure to attach the documentation described for each choice. Failure to send the required documentation will significantly delay processing.

The Applicant is homeless as defined by HUD because he or she (CHOOSE ONE):

- ☐ **Lives in places not meant for human habitation, such as a cars, abandoned buildings, parks, sidewalks, etc. ("on the street").**
☐ *Documentation attached:* letter from an outreach worker or other homeless services worker able to verify the applicant's street homelessness; or a letter describing the Applicant's street homelessness signed and dated by the Applicant.
- ☐ **Lives in an emergency shelter.**
☐ *Documentation attached:* letter from the shelter(s) in question verifying the applicant has been residing at the shelter
- ☐ **Lives in transitional or supportive housing for homeless persons whose prior housing was emergency shelters or places not meant for human habitation.**
☐ *Documentation attached:* letter from the transitional housing facility in question verifying the applicant has been residing in the transitional housing; **AND**
☐ *Documentation attached:* letter from the shelter(s) verifying the applicant has been residing at the shelter; **OR**
☐ *Documentation attached:* letter from outreach worker or other homeless services worker able to verify the applicant's street homelessness; or a signed dated letter from applicant's case manager attesting to the client's street homelessness.
- ☐ **Is currently spending thirty consecutive days or less in a hospital, in-patient treatment program, jail, or other institution but prior to the institution lived in an unsheltered setting or emergency shelter.**
☐ *Documentation attached:* signed and dated verification from the institution staff that the applicant has been residing there for thirty days or less; **AND**
☐ *Documentation attached:* letter from the shelter(s) in question verifying the applicant was residing at the shelter(s) prior to going to the institution; **OR**
☐ *Documentation attached:* letter from outreach worker or other homeless services worker able to verify the applicant's street homelessness; or a signed dated letter from applicant's case manager attesting to the client's street homelessness prior to being in the institution.

How long did the Applicant stay in the situation checked above prior to the date of this application?

- ☐ One week or less
☐ More than one week but less than one month
☐ One-three months
☐ More than three months but less than one year
☐ One year or more
☐ Don't know
☐ Refuse to answer

What was the Applicant's last permanent address (where they last owned a home, paid rent or had a stable family situation)?

Street address: _____
City: _____ Zip Code: _____

Don't Know ☐ Refuse to Answer ☐

➤ _____
(Print Name of Case Manager)

➤ _____
(Signature of Case Manager)

➤ _____
(Name of Referring Agency)

➤ _____
(Date)

Applicant's Name: _____

➤ **ATTACHMENT D. VERIFICATION OF CHRONIC HOMELESSNESS**

PURPOSE: "Chronic homelessness" is the term HUD applies to single individuals who are disabled and who experience long-term and/or frequent episodes of homelessness. Several DMH Shelter Plus Care grants are reserved only for people who fit this definition. *Please fill this form out whether or not the Applicant fits the definition of chronically homeless.*

In order to be designated as chronically homeless, a person must meet all three of the conditions shown below. Please indicate whether the applicant meets each condition by checking the appropriate box.

1. The applicant is an unaccompanied homeless individual who is not part of a homeless family and is not accompanied by a child or children, a spouse, or any companion.

Yes ☐ No ☐

2. The applicant has a disabling condition defined as a diagnosable alcohol or drug abuse disorder, serious mental illness, developmental disability, or chronic physical illness or disability, including the co-occurrence of two or more of these conditions.

Yes ☐ No ☐

- 3a. The applicant has been continuously homeless for a year or more living on the streets and/or in an emergency homeless shelter.

Yes ☐ No ☐

OR

- 3b. The applicant has had at least four episodes of homelessness in the past three years that are distinct and sustained stays on the streets and/or in emergency shelters where the applicant was unaccompanied and disabled during each episode.

Yes ☐ No ☐

Use the area below, if needed, to provide further details regarding the applicant's status as chronically homeless:

➤ _____ ➤ _____
(Print Name of Case Manager) (Signature of Case Manager)

➤ _____ ➤ _____
(Name of Referring Agency) (Date)

➤ ATTACHMENT E. REQUIRED HMIS INFORMATION

➤ ADULTS		(Applicant Name)	(Other Adult Name)	➤ CHILDREN		(Name)	(Name)	(Name)
EDUCATION	In school? (yes/no)			EDUCATION	Enrolled? (yes/no)			
	Vocational training? (yes/no)				If not enrolled, state reason			
	Highest grade completed				If enrolled, type of school			
			Name of School					
VETERAN STATUS	Branch			HEALTH STATUS	General health Status			
	Duration of active duty				Pregnant? (if yes, give due date)			
	Discharge status							
	Service era			EMPLOYMENT STATUS	Employed? (if yes, state tenure type)			
	Served in war zone? (if yes, no. of months.)				Hours worked last week			
	War zone served in				If not employed, looking?			
	Rec'd hostile or friendly fire?				Able to work?			
	Registered at VA? If yes, give record number				PURPOSE OF THIS FORM: "HMIS" stands for Homeless Management Information System, an on-line database of information about homeless services and the people who utilize those services. There are different HMIS systems for the cities and rural areas of Missouri, and DMH participates in all of them. We collect this information to help homeless service providers better understand the needs of people who experience homelessness. See the attached instructions for help in completing this form. NOTES/COMMENTS:			
DOMESTIC VIOLENCE HISTORY	Victim of domestic violence? Yes / No							
	Date occurred							
	How long In past?							
HEALTH STATUS	General health status							
	Pregnant? (If yes, give due date)							
EMPLOYMENT STATUS	Employed? (if yes, state tenure type)							
	Hours worked last week							
	If not employed, looking?							
	Able to work?							

➤ INSTRUCTIONS FOR ATTACHMENT E. REQUIRED HMIS INFORMATION

Required HMIS Information. Please refer to the following lists to enter the information requested on page 1. Enter number codes as shown below, where appropriate; or, if space is available, enter a written answer based on the choices shown below. Use additional sheets if there are more than three children in the household.

➤ EDUCATION: Adults:

- **In School?:** state “yes” or “no” (includes college work, GED classes, high school)
- **Vocational Training?:** state “yes” or “no” (includes apprenticeship training)
- **Highest Grade Completed:** 1: high school diploma; 2: G.E.D.; 3: one year of college, technical or vocational education; 4: two years of college, technical or vocational education; 5: three years of college, technical or vocational education; 6: Bachelor’s Degree or equivalent; 7: Five or more years of college, Master’s Degree or Ph.D.; 8: 11th-12th grade with no diploma; 9: 10th grade with no diploma; 10: 9th grade with no diploma; 11: 8th grade with no diploma; 12: 7th grade with no diploma; 13: 6th grade with no diploma; 14: 5th grade with no diploma; 15: 4th grade with no diploma; 16: 3rd grade with no diploma; 17: 2nd grade with no diploma; 18: 1st grade with no diploma; 19: no grade completed

➤ EDUCATION: Children:

- **Enrolled?:** state “yes” or “no” (pre-school through 12th grade)
- **If Not Enrolled, State Reason:** 1: residency required; 2: prior school records not available; 3: no birth certificate; 4: legal guardian requirements; 5: transportation problems; 6: lack of pre-school programs; 7: immunization requirements; 8: physical exam records not available; 9: other; 10: none
- **If Enrolled, Type of School:** 1: public; 2: parochial or private school
- **Name of School:** give name if known

➤ VETERAN STATUS: Adults:

- **Branch (of Service):** 1: Army; 2: Air Force; 3: Navy; 4: Marines; 5: other
- **Duration of Active Duty:** enter number of months served
- **Discharge Status:** 1: Honorable; 2: General; 3: Medical; 4: Bad Conduct; 5: Dishonorable; 6: other
- **Service Era:** choose one; if the service dates overlap two Service Eras, choose the one containing the majority of the service time. 1: Persian Gulf (8/1991-Present); 2: Post-Vietnam (5/1975-7/1991); 3: Vietnam (8/1964-4/1975); 4: Between Korea and Vietnam (2/1955-7/1964); 5: Korea (6/1950-1/1955); 6: Between WW2 and Korea (8/1947-5/1950); 7: WW2 (9/1940-7/1947); 8: Between WW1 and WW2 (12/1918-8/1940); 9: WW1 (4/1917-11/1918)
- **Served in War Zone?:** if “yes”, give number of months served; if “no”, state “no”
- **War Zone Served in:** 1: Europe; 2: North Africa; 3: Vietnam; 4: Laos/Cambodia; 5: South China Sea; 6: China/Burma/India; 7: South Pacific; 8: Persian Gulf; 9: other
- **Rec’d Hostile or Friendly Fire?:** state “yes” or “no”
- **Registered at VA?:** if “yes”, provide VA record number if known; if not registered, state “no”

➤ DOMESTIC VIOLENCE HISTORY: Adults:

- **Victim of Domestic Violence? Yes/No:** self-explanatory
- **Date Occurred:** provide most recent date of victimization
- **How Long in Past?:** 1: within past three months; 2: three-six months ago; 3: six-twelve months ago; 4: more than one year ago; 5: don’t know; 6: refused to say

➤ HEALTH STATUS: Adults and Children:

- **General Health Status:** 1: excellent; 2: very good; 3: good; 4: fair; 5: poor; 6: unknown
- **Pregnant?:** indicate a “yes” answer by entering a delivery date; if “no”, enter “no”

➤ EMPLOYMENT STATUS: Adults and Children:

- **Employed?:** indicate a “yes” answer by stating the type of employment tenure: 1: permanent; 2: temporary; 3: seasonal
- **Hours Worked Last Week:** state the number of hours worked in week prior to intake
- **If Not Employed, Looking?:** state “yes” or “no”
- **Able to Work?:** state “yes” or “no”

➤ ATTACHMENT F. AUTHORIZATION FOR DISCLOSURE OF CONSUMER MEDICAL/HEALTH INFORMATION

I, _____ authorize and request: <small>(Name of Consumer, Parent, Guardian/Legal Representative)</small>	
<input checked="" type="checkbox"/> Dept. of Mental Health <input type="checkbox"/> Dept. of Elementary and Secondary Ed	<input type="checkbox"/> Dept. of Social Services <input type="checkbox"/> Other _____ <small>(Name of indicated Facility, Agency, Mental Health Center, Person)</small>
to disclose/release the below-specified information of (name) _____	
(date of birth): _____ (social security number): _____	
who received services from _____ to _____ <small>(Date) (Date)</small>	
to: <input type="checkbox"/> Dept. of Mental Health <input type="checkbox"/> Dept. of Elem. & Secondary Ed.	
<input type="checkbox"/> Dept. of Social Services <input checked="" type="checkbox"/> Other: Rent Subsidy Processing Center, local housing authority, landlord, HMIS data system, HUD <small>(Name of indicated Facility, Agency, Mental Health Center, Person)</small>	
_____ <small>(Address)</small>	
_____ <small>(City, State, Zip)</small>	
The Purpose of this Disclosure is: <input type="checkbox"/> Aftercare <input type="checkbox"/> Placement <input type="checkbox"/> Transfer/Treatment <input type="checkbox"/> Treatment Planning <input type="checkbox"/> Assessment <input type="checkbox"/> Consumer Request <input type="checkbox"/> Conditional/Unconditional Release Hearing <input checked="" type="checkbox"/> Eligibility Determination <input checked="" type="checkbox"/> Continuity of Services/Care <input type="checkbox"/> To share information with above agencies to obtain services consistent with _____ <small>(Name of program)</small>	
<input checked="" type="checkbox"/> Other: Info. for securing and/or maintaining rental assistance and housing from DMH or local housing authority	
The Specific Information to be Disclosed is: <input type="checkbox"/> Discharge Summary <input checked="" type="checkbox"/> Treatment Plan and/or Reviews <input type="checkbox"/> Medical/Psychiatric Assessment(s) <input type="checkbox"/> Progress Notes <input type="checkbox"/> Social Service Assessment <input type="checkbox"/> For DD, testing: psychometric, neurological, IQ results, or other developmental test results <input type="checkbox"/> Educational Testing, IEP, transcript, grading reports <input checked="" type="checkbox"/> Other: General disability verification related to rent subsidy requirements, income, support provider contact information	
<p>PLEASE READ CAREFULLY: I understand that my medical/health information records are confidential. I understand that by signing this authorization, I am allowing the release of my medical/health information. The protected health information (PHI) in my medical record includes mental/behavioral health information. In addition, it may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), human immunodeficiency virus (HIV), other communicable diseases, and/or alcohol/drug abuse.</p>	
1. Alcohol and drug abuse information records are specifically protected by federal regulations (42 CFR 2) and by signing this authorization without restrictions I am allowing the release of any alcohol and/or drug information records (if any) to the agency or person specified above. Please sign if you are authorizing the release of alcohol and drug abuse information: <div style="text-align: right; margin-top: 20px;"> _____ <small>(Consumer signature)</small> </div>	
2. This authorization includes both information presently compiled and information to be compiled during the course of treatment at the above-named facility during the specified time frame.	

3. This authorization becomes effective on _____. This authorization remains effective until the consumer is no longer a participant in the rent subsidy program, unless the consumer specifies an expiration on the following date, or based on the following event or special condition: _____

4. I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so **in writing** and present my written revocation to the health information management department (medical records) or client information center at this facility. I further understand that actions already taken based on this authorization, prior to revocation, will **not** be affected.

5. I understand that I have the right to receive a copy of this authorization. **A photographic copy of this authorization is as valid as the original.**

6. I understand that authorizing the disclosure of this medical/health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may request to inspect or request a copy of information to be used or disclosed, as provided in 45 CFR Section 164.524. I understand that any disclosure of information carries with the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my medical/health information, I can contact the health information management director (medical records director) or client information center, or designee, or the Privacy Officer for this covered entity.

7. **THE FOLLOWING STATEMENT APPLIES TO ANY ALCOHOL AND/OR DRUG ABUSE TREATMENT INFORMATION RECORDS THAT WE DISCLOSE:** Prohibition on Redisclosure: This information has been disclosed to you from records whose confidentiality is protected by Federal law. Federal regulations (42 CFR Part 2) prohibit you from making further disclosure of it without the specific written authorization of the person to whom it pertains, or as otherwise specified by such regulations. A general authorization for disclosure of medical or other information is NOT sufficient for this purpose.

My signature below acknowledges that I have read, understand, and authorize the release of my PHI.

Signature of Consumer: _____

Date: _____

Signature of Witness: _____

Date: _____

**Signature of Parent/ Legal
Guardian/Representative:** _____

Date: _____

(Please include a Description of Authority to Act on Consumer's Behalf):

NOTICE OF REVOCATION

I, _____ (Consumer) **hereby revoke my authorization** of this disclosure of information to the agency/person listed above. This revocation effectively makes null and void any permission for disclosure of information expressly given by the above authorization. I understand that any actions based on this authorization, prior to revocation, will not be affected.

Signature of Consumer: _____

Date: _____

Signature of Witness: _____

Date: _____

**Signature of Parent/ Legal
Guardian/Representative:** _____

Date: _____

If you choose to revoke your authorization, please provide a copy of the completed revocation to the Health Information Management Director (Medical Records Director), or the Client Information Center, or to the Privacy Officer of this facility.